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A descriptive study of the experiences of lesbian, gay and transgender parents accessing health services for their children

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Aim. To explore the experiences of lesbian, gay and transgender families accessing health care for their children.

Background. Although lesbian, gay and transgender families are becoming more common, little is known about their health-seeking experiences. These families may be fearful about disclosing their sexual orientation or gender identity to health professionals. As a result, lesbian, gay and transgender parents may not be receiving optimal care for their children.

Design. Descriptive qualitative study.

Method. Data were collected through semi-structured interviews with 11 lesbian, gay and transgender parents in Australia.

Results. Three themes were generated from the data: 'managing health care experiences', 'attitudes' and 'transforming bureaucracies'. Negative experiences included encountering homophobia or transphobia and being required to educate health professionals. Positive experiences occurred when both parents were acknowledged as having an equal say in their child's health care.

Conclusion. Many health professionals lack the skill or knowledge to meet the needs of lesbian, gay and transgender families. Health services are required to ensure that all policies and procedures are inclusive of all family constellations and that staff receive relevant and up-to-date sensitivity training and create an environment that is respectful of all family groups.

Relevance to clinical practice. Adopting a philosophy of family centred care can enable health providers and health professionals to provide lesbian, gay and transgender families with inclusive non-discriminatory care.

Key words: family centred care, gay, gay families, homosexuality, lesbian, parents, transgender

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Introduction

Parenting by lesbian, gay, bisexual and transgender (LGBT) persons is becoming increasingly common and more widely accepted (Telingator & Patterson 2008, Chapman *et al.* 2011). Being lesbian, gay or bisexual (LGB) relates to sexual orientation [the gender(s) to whom someone is sexually attracted]. For instance, a gay man is sexually attracted to men, a lesbian woman is sexually attracted to women and a bisexual person is sexually attracted to both men and women (Dean *et al.* 2000). Being transgender (T) is a matter of gender identity (a person's sense of themselves as being a man or a woman), and transgender people have a different gender identity than is commonly expected based on their sex characteristics (Dean *et al.* 2000). For instance, transwomen are born with male bodies, but desire to live as women and may undergo medical treatments to feminise their body. Some transgender people are heterosexual, whilst others are

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transgender and also LGB (Dean *et al.* 2000). Partners of transgender people can be heterosexual or LGB.

Background

Many LGBT parents may be unwilling to 'come out' to health professionals because of concerns about discrimination and bullying (Garcia 2003, Perrin *et al.* 2004, Polek *et al.* 2008). These fears become increasingly significant when LGBT parents access health care for their children (Perrin *et al.* 2004). No equivalent research has been identified for transgender parents. Insensitivities of health care providers and poor past experience with health systems are the main reasons LGBT persons avoid or delay presenting at health agencies (Couch *et al.* 2007, Polek *et al.* 2008).

These concerns are significant for nurses working in paediatrics. Nonetheless, we located only a few studies that focus on lesbian and gay parents' experiences of accessing health services for their children (Neville & Henrickson 2008), and we were unable to find any that explored these issues for transgendered families. To address this gap, we explored the perceptions of LGBT families receiving health care services in Australia. This information will assist clinicians, educators and hospital management to develop policies and practices that ensure LGBT families receive quality, non-prejudiced, holistic healthcare.

Homophobia, which is the fear and dislike of lesbian and gay people, and transphobia, which is the fear and dislike of transgender people, have been shown to be major barriers to receiving and providing quality health care to LGBT persons (Klitzman & Greenberg 2002, Couch *et al.* 2007, Neville & Henrickson 2008, Chapman *et al.* 2011). Many transgender individuals also report experiencing homophobia on the basis of their perceived sexual orientation (Hill & Willoughby 2005, Xavier & Bradford 2005). Heterosexism is the belief that heterosexuality is the norm and that people can be presumed to be heterosexual (Irwin 2007, Chapman *et al.* 2011), and the health care system is shaped by both heterosexism and a lack of awareness of transgender people's lives and needs, which consequently may enforce social invisibility on LGBT families (Neville & Henrickson 2006, 2008, Couch *et al.* 2007, Chapman *et al.* 2011). Social invisibility 'perpetuates stigma and shame and undermines a sense of the full meaning of life, morale and well-being' for LGBT people (Webber 2008, p. 609).

As well as dealing with external threats, LGBT parents may also be dealing with their own internalised homophobia and/or transphobia, which can lead to shame, hostility, self-blame and anxiety (Telingator & Patterson 2008). Therefore, it is not surprising that LGBT parents are reluctant to 'come out' to health care providers (Neville & Henrickson 2008). The disclosure of a person's sexual orientation can lead to an increased use of health services and better satisfaction with care (Barbara *et al.* 2001, Bergeron & Senn 2003). For health professionals to address the needs of LGBT families, it is important that they have an understanding of the challenges and issues experienced by these parents and provide a safe environment where the disclosure of sexual identity is encouraged when relevant.

Aims

This study aimed to explore and describe the experience of LGT parents accessing health care for their children.

Design

This qualitative, descriptive exploratory study used face-to-face interviews to collect detailed data about the experience of LGT parents accessing health care for their children. Whilst the research initially aimed to include LGBT parents, no participants identified as bisexual. Therefore, this research paper addresses LGT parents rather than LGBT parents. Five participant couples were recruited by leaflet drop and flyers during *Pride Fair Day,* a family event celebrating the LBGT community. A further six participant couples were also recruited using the snowball sampling technique. This technique allowed us to use existing networks to identify and access other participants who met the inclusion criteria (LGBT parents) and had experience in the subject area. This form of sampling is especially useful when populations are hidden or isolated, as individuals may be more willing to participate if they have been referred by another member of their group (Berg 2009). Ethics approval was gained from a university human research ethics committee. All participants were given an information sheet about the study and gave written informed consent prior to participating in the interviews.

Data collection

Semi-structured interviews or 'conversations' were conducted with both couples and individuals to explore LGT parents' experience of seeking health care for their children. The purpose of these conversations was to gather information about the phenomenon under study (Liamputtong & Ezzy 2005, Berg 2009), and the open-ended interview questions were derived from the aims of the study. Some examples of the questions asked were as follows: can you tell me about your current relationship situation? Can you tell me about a

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time that you have sought health care services for yourself? Can you tell me about a time that you sought health care services for your child/children? An interview guide was used in each interview with a set of questions and prompts to reduce researcher bias. All of the interviews were digitally recorded and transcribed verbatim. Data collection was continued until saturation occurred, that is, when no new information emerged (Sandelowski 1995). Saturation was reached after 11 interviews with LGT parents.

Data analysis

Data collection and analysis were conducted in parallel, and the interpretation and coding was approached from a qualitative descriptive framework. This approach does not require a highly abstract rendering of the data and is a method of choice when fundamental descriptions of phenomena are required (Sandelowski 2000). Transcripts were analysed using standard processes of qualitative analysis as identified by Speziale-Streubert and Carpenter (2003) and included coding, finding categories, clustering and identifying patterns and meaning. In accordance with Strauss and Corbin (1990), the data were reflected on and coded line-by-line to identify significant meanings, that is, words or phrases that the participants used and which we identified as being of interest or importance. The coded meanings were then categorised and clustered, and the relationship between them identified, thus confirming that the themes which emerged were adequate and informative.

Trustworthiness was achieved by addressing credibility and transferability of the data (Lincoln & Guba 1985, Fossey *et al.* 2002). Credibility was ensured by giving a sample of the transcripts to two experts in qualitative data analysis, who coded and categorised the data individually, with overall agreement and consistency between the experts' and the researcher's analysis. Transferability was established by developing rich descriptions and maintaining an audit trail to allow comparison of our study with those conducted in similar contexts. The following section provides statements that illustrate the main categories, and statements are identified by interview number to help preserve anonymity.

Findings

The families participating in this study lived in several areas of Australia including Western Australia, Queensland, Australian Capital Territory and New South Wales and included seven lesbian couples, one gay couple and three couples for which one partner was transgender; including one person in the process of male to female (MTF) transition, one person in process of female to male (FTM) transition and one person who had completed FTM transition. No bisexual people participated. Our families' origins included children from previous heterosexual marriages, conception through the use of *in vitro* fertilisation or donor insemination and adoption. On many occasions, these families were formed prior to legislative changes in Australia providing LGBT people with similar, but not exactly the same, rights as heterosexuals (Summers 2007).

Together, the families are parenting 16 children aged from 1–20 years, with equal numbers of girls and boys. The parents' highest education qualification ranged from high school certificate to postgraduate university degrees. All but one of the families live in their own homes, and at least one parent in each couple is employed in paid work. The following themes emerged from the data: 'managing health care experiences', 'attitudes' and 'transforming bureaucracies'.

Managing health care experiences

Whilst many of our participants have had positive experiences with health systems and providers, they simultaneously recognise that their relationships in these systems are negotiated and complex. In this section, we unpack ways our participants negotiated pathways through the health system and examine opportunities, limiting factors and constraints that led them to recognise specific incidents or attitudes as positive or negative:

> ...I don't find that there's a lot of discrimination within it [healthcare]. The nature of health is that the people involved are caring and have seen everything anyway. But not always... (Interview 1)

This quote is a telling summation of the current situation as one politically sensitive participant sees it. However, it opens up an underlying and persistent dissonance. One couple, in particular, exemplified the 'learning curve', in which several parents recognised that they (as well as health professionals) have participated: 'I think sometimes the doctors will pointedly say "well which of you is the parent, like which one of you is the mother?"' Here, one partner felt ignored and excluded by the doctor. Her partner tried to reassure her, and in their determination not to dwell on negatives, this couple refocussed their own attention to the confusion for the medical staff and their medical need to know who the birth mother was. They recognised, too, the possibility that they might have reacted more because of their own stress about their sick child: '… if you were very hypersensitive… You could get offended by that… it's just the situation really…' (Interview 2).

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All our participants have a sense of the everyday politics of being LGT couples, parents and families, whilst several in particular underpin this with a developed political philosophy, which translates as activist and engaged. This philosophy and engagement has assisted many of our participants to successfully navigate the health care system. In fact, some politically aware participants considered it their responsibility to educate staff about LGT families:

... I believe that every one of us who is comfortable and secure in their life has an education role and it is our job to make the way easier for other people by explaining who we are and helping to break down the stereotypes and I think... if you've got the strength and you're in a position where you can do it you really do have that responsibility... (Interview 6)

Another couple comfortable in their 'normality' stated 'We're just like everyone else so people tend to treat you like that. And health services do as well, after that initial hiccup of my God … how does this family all fit together?' (Interview 7).

However, the experience is not the same for everyone as one of the partners of another transgender family explained:

...I felt like I have spent a lot of time educating everyone [health professionals]... trans stuff is not very well known... our situation is different to a lot of LGBT people... I'm [non-transgendered partner] sort of along for the ride... I don't always have the energy or the desire to educate people... when you are going to people for help and you need to educate them it can be very difficult because that's when you are vulnerable and when you need support... (Interview 10)

Families with a transgender parent often reported that health care providers had little awareness of how to respectfully engage with the family or refer to the transgender parent. In articulating these experiences of health care access, some participants acknowledge their awareness that others are not so fortunate in their interactions with the system and find ways to understand why that is so:

...some of these rules are in place for stupid reasons and I think that some lesbians and gay men can take things very personally and it's a personal attack on me because of my sexuality...and they take that approach because of the experiences they've had in the past and they're very defensive… (Interview 1)

Most participants had moments when health care access was not perfect, and most read this as not being out of the ordinary, for example: 'we got the run around a little bit, but not more than any other normal parent would' (Interview 2).

Underlying this is an understanding, which some participants had, that being attentive to social systems and organisations eases the way:

...we've found that rather than stamp our feet, shave our heads and jump up and down … approaching it quietly and pointing it out is often [enough]. Or working at things behind the scene and just tap, tap, tapping away, until you see a change... (Interview 1)

Attitudes

Our participants experienced both positive and negative interactions with health professionals and providers. One assertive couple explained that they:

... had previously tried to get health insurance as a family and we went to X [private health insurer] and they said we don't cater to people like you, you're not a family. I went f**k you … that was offensive and I just wouldn't accept anybody saying that to us as a service provider... (Interview 6)

Although some told us that that not being acknowledged as a family is now in the past, most have had negative experiences in the very recent past. For example:

...We chose an obstetrician who hadn't had a gay couple before … he said don't bring any of your friends back... when he rang pathology or other services, the same man would say 'I've got the same sex couple' and when she asked him about that he said 'oh I don't know', leaving the question open about whether he was actually homophobic or simply out of his depth?... (Interview 7)

The interactions that our participants perceived as positive were those when health professionals did not judge or make assumptions about them and were focused on the reason for seeking healthcare, rather than the fact that the family has LGBT parents:

... she [health professional] didn't judge she didn't make an assumption or [make us] fit into a mould... even people who have lived as LGBT their whole lives don't like to be labelled either... having to be pushed into a category and pushed into assumptions about what you are... [is] hurtful and stressful... not to assume anything was really important... she [health professional] was great that relationship was very helpful... (Interview 10)

Experiences were also viewed as positive by the participants when health professionals acknowledged both parents had an equal say and responsibility for the health care of their child. One couple explained: 'the nursing staff were just awesome. They knew from the word go that we were a couple… I was treated as the other parent' (Interview 1).

Participants perceived a need for more sensitivity and awareness training for health professionals. Clearly, it is still common for health professionals to focus on one mother or father rather than two parents, seeking to know who the birth mother is and then ignoring the other mother, or not

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knowing what to do with two fathers. A focus on genetic history when none is available (adopted children or those born of unknown donors) led to embarrassment and frustration. This sensitivity towards LGBT clients extends to health professionals using correct pronouns when dealing with transgendered parents: 'she [partner] lives as a woman and I need to see her as a she and you [health professional] need to use the right pronouns...' (Interview 10). A further example is when one parent took his child to the dentist:

.... I was passing [as male] most of the time... he [dentist] paused and looked at me and even though X [daughter] kept calling me X [male name] he [dentist] kept referring to me as mummy... he didn't get that or have any idea about it [transgendered people]... (Interview 11)

An example of a melodramatic reaction of a health professional to a couple coming out as lesbian was that of the child health nurse at a local chemist. The couple had been accessing the child health nurse at the chemist since the birth of their child. However, when they came out to the nurse she:

...ran, so fast across the other side of the pharmacy and she didn't speak to me for weeks … I suppose because we hadn't said anything to her before... But why should you have to explain yourself to everybody?... (Interview 7)

A common thread running through these narratives, however, is that much depends on who is reading the situation and how they are doing so:

… our obstetrician and he is, fantastic. People hate him or love him... and we're on the love him category. He's a very blunt person and I think that if you had a more sensitive lesbian couple they would be telling you a different story... (Interview 1)

Transforming bureaucracies

Bureaucratic attitudes and positions can be read through the rhetoric of forms. Prior to legislative reform, health-related forms reproduced traditional social relationship patterns, for example, a couple explained:

...everywhere we go the forms are wrong. I mean it sounds like such a small thing but it's always mother and father and I always cross it out and put mother two... I don't get offended I just correct it.... (Interview 6)

Several participants recorded their awareness and frustration that differing family compositions are not yet widely recognised. Centrelink, the Australian government authority responsible for providing access to government services, including social security allowances, has changed its forms to read partner 1, partner 2. However, in many areas of the health system, the forms still use 'mother and father': 'we sort of take it in turns to cross out mother and put the other one [parent] in' (Interview 5).

Discussion

This study provides health professionals with an understanding of the experiences of LGT parents seeking health care for their children. In addition, it is the first of its kind to include the perceptions of transgendered families. Many of our families experienced negative interactions with health professionals. Family as the constant in the child's life, respect, collaboration and effective communication are the tenets of family centred care (FCC) (Shields *et al.* 2006) and provide a framework from which our findings can be examined. The main concerns for the parents included the attitudes of health professionals when one parent was ignored or excluded from their child's care, the necessity to 'come out' repeatedly, having to negotiate the system because of their family constellation, encountering homophobia, transphobia or both in health settings and engaging with bureaucracies that assume people are heterosexual and non-transgendered.

Similar to lesbian mothers in McNair *et al.*'s (2008) study, we found LGT parents and their partners carefully negotiated their interactions with the health care system. Many parents disclosed their sexual orientation or gender identity to health professionals, and when they considered that one parent was being excluded, they acted to address the oversight.

For our LG families, it was important that both parents were acknowledged by health professionals and had equal roles and responsibilities in their child's healthcare. When this acknowledgement occurred, parents viewed their experience as positive. McNair *et al.*'s (2008) lesbian parents deliberately disclosed their sexual orientation as one way to ensure that both mothers were viewed as equal partners. This finding is important because it requires health professionals to not only be willing to engage with families from diverse backgrounds but to also ensure that they are knowledgeable about potential challenges and issues encountered by LGT families and demonstrate sensitivity when caring for these parents.

Participants were frustrated by the lack of respect displayed by Australian bureaucratic systems. Systems were often heteronormative and exclusionary to transgender people, as a result of the assumptions of practitioners and services that everyone is heterosexual and non-transgender and that all children have both a mother and father. Families where one parent was transgender reported many similar health care experiences to lesbian and gay parents; and such a finding is consistent with literature that documents

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associations between homophobia and transphobia (Hill & Willoughby 2005, Xavier & Bradford 2005). Clinical interactions where practitioners used terms of reference for parents, for instance when the practitioner used terms such as 'mother' or 'father', also could be problematic for LGT families. In addition, forms that assumed parents to be heterosexually coupled and non-transgender, for instance requesting the details of the mother and father in the family, were notably problematic for LGT families.

Government forms, including forms used by health agencies, reflect and reproduce unconscious or unacknowledged discriminatory attitudes towards LGBT families. These attitudes will continue to be reinforced until the language of bureaucracies, variously reproduced, including forms, brochures and websites, is non-gender specific and inclusive of all the possibilities of family composition. Possible family compositions include transgendered parents who may have a different legal sex from their parenting role and are often ignored in such resources.

Although there were only three transgender participants and their partners in this study all were frustrated that they were often required to educate health care providers about transgender matters to access appropriate care, the consultative sharing of knowledge between a health professional and transgender person can be mutually beneficial (Couch *et al.* 2007). However, health professionals have the responsibility to educate themselves rather than to place this responsibility on their patients (Australian Nursing Council 2002, Gay & Lesbian Medical Association [GLMA] 2009, Medical Board of Australia 2011).

We argue that Australian culture is heterosexist and transphobic. Consequently, LGT people have less visibility and inclusion, thus impeding the effective communication required for FCC (Shields *et al.* 2006). Family-centred care is widely professed as a model of care in paediatric health facilities worldwide (Shields *et al.* 2006). It requires an understanding of all types of families, including those from different cultures and in different situations. For LGT-parented families, FCC can be implemented fully only if the health care providers delivering that care are sensitive to the context, functions and constructs of the family in question (Shields 2010). Family-centred care recognises all family members as care recipients and acknowledges the child's family as pivotal in their care (Shields *et al.* 2006). A lack of understanding of the needs of LGT-parented families is an impediment to the effective delivery of FCC.

Unless the participants disclosed their sexuality or gender identity, it was always assumed they were heterosexual and not transgendered. Such an assumption can lead to health professionals providing inappropriate care and wrong information to LGT clients and their children. Disclosing one's sexual orientation and identity can lead to better health outcomes and higher satisfaction with the health service environment (Barbara *et al.* 2001). However, it is important to note that some of our transgendered parents had the unambiguous appearance of the gender with which they identified. These participants acknowledged that they were treated as who they wanted to be, that is, a 'normal heterosexual couple' without their transgender status being identified, and this was how they wished to be regarded. Therefore, it is important to enable parents to choose to disclose when and if that information is relevant to the health care situation. Providing FCC requires health professionals to demonstrate respect for all families regardless of their constellation and is inclusive of all family members (Shields *et al.* 2006). By adopting the FCC model, health services can ensure that staff are providing effective, optimal holistic care for these families.

In addition and to facilitate improved collaboration for FCC, it is imperative that health services review policies, procedures and environments and address issues and concerns expressed by our and other LGT families (McNair *et al.* 2008). Ways in which health services can promote cultural change and the delivery of more inclusive and less discriminatory care include: (1) provide forms and publications that use non-gendered and non-heterosexist language (parent rather than mother/father, partner rather than husband/wife, gender rather than sex); (2) develop admission and assessment forms that require staff to ask non-gender specific questions regarding parenting, including not assuming that the non-attending parent is of a different gender; (3) ensure health professionals use the correct pronoun and name that a transgendered parent wishes to be used. For example, referring to a MTF-transgendered person as 'she' and FTM as 'he'; (4) ensure both parents are included in the health care of their child, and their rights and responsibilities are respected and acknowledged; (5) create an environment that is inclusive of all families by not tolerating anti-LGT language and ensuring that discriminatory language is removed; and (6) provide current and up-to-date education for staff about the special needs and issues of LGT families, including sensitivity and awareness training. Because LGT families are in the minority, health professionals may have little experience managing this group. Therefore, even well-intentioned care providers may lack the appropriate skills or knowledge to effectively communicate in the context of all non-traditional family configurations. Only with education and understanding on both sides (which was ably displayed by many of our respondents) will these difficulties be overcome and FCC be appropriately implemented.

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There is a paucity of research investigating the experiences of LGT families. The reasons for this oversight relate to the relative small numbers of families, parents' fear of disclosure, differences in the assemblage of the family groups and the lack of funding available to support research in this area. Therefore, it is imperative that empirical research be funded and conducted to enable health professionals and agencies to provide services that do not condone or perpetuate discrimination against these families and the findings used to develop and implement relevant and up-to-date education. This strategy will enable health professionals to provide LGT parents and their children with effective optimal care.

Limitations

Our qualitative study provides a 'snap shot' of a small number of LGT parents' experiences of accessing health care for their children, and thus the generalizability of our findings to other contexts may be limited. In particular, because our small number of participating-transgender parents reported numerous difficulties in seeking health care for their children, further exploratory research involving a broad sample of transgender parents would be valuable.

Conclusion

LGT families continue to experience negative attitudes from health professionals. The participants in this study experienced both positive and negative interactions with health professionals. The negative interactions included one of the parents being excluded from the health care experience, the need to 'come out' and encountering homophobia or transphobia. When both parents were acknowledged as having an equal say in their child's health participants viewed this as a positive experience. Health services can improve the quality and effectiveness of the care provided to these parents by ensuring that all policies and procedures are inclusive of all family constellations, staff receive relevant and up-to-date sensitivity training and by creating an environment that is respectful of all family groups. One way to achieve this outcome is to implement a philosophy of FCC. This paper is the first to include the experiences of transgendered parents and their partners seeking health care for their children and as such provides new knowledge about this phenomenon.

Relevance to clinical practice

Adopting a philosophy of FCC that includes respecting LGT families can enable health professionals to provide LGT families with inclusive non-discriminatory care.

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Contributions

Study design: LS, RC, JW; data collection and analysis: PF, TZ, RW and manuscript preparation: RC, LS, JW, TZ, RW, PF.

Conflict of interest

The authors declare that they have no conflict of interests.

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